Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ENGS PHARMACY LLC
PO BOX 2686
STAFFORD TX 77497

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

INSURANCE CO OF THE STATE OF PA

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-12-1700-01

MFDR Date Received

January 20, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "no payment/EOB after 2 attempts"

Amount in Dispute: $2,333.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent, or its agent, did not respond to the request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 26, 2011	ZOLPIDEM TARTRATE 10 MG TAB – 60 Units Generic NDC: 13668000801	$350.90	$350.90
July 26, 2011	TIZANIDINE HCL 4 MG TABLET – 150 Units Generic NDC 00185440051	$278.80	$278.73
July 26, 2011	HYDROCODON-APAP 10-650 – 200 Units Generic NDC: 00406036162	$292.90	$292.88
September 22, 2011	HYDROCODON-APAP 10-650 – 200 Units Generic NDC: 00406036162	$292.90	$0.00
September 22, 2011	ZOLPIDEM TARTRATE 10 MG TAB – 60 Units Generic NDC: 13668000801	$350.90	$0.00
October 22, 2011	TIZANIDINE HCL 4 MG TABLET – 150 Units Generic NDC 00185440051	$278.80	$278.73
October 22, 2011	ZOLPIDEM TARTRATE 10 MG TAB – 60 Units Generic NDC: 13668000801	$350.90	$350.90
October 22, 2011	HYDROCODON-APAP 10-500 – 200 Units Generic NDC: 00591054001	$137.20	$137.18

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. Texas Labor Code §401.011(22) defines "health care provider" as a "health care facility" or "health care practitioner."
3. Texas Labor Code §401.011(19)(E) defines "health care" to include a prescription drug, medicine, or other remedy.
4. Texas Labor Code §401.011(20) defines "health care facility" as a hospital, emergency clinic, outpatient clinic, or other facility providing health care.
5. 28 Texas Administrative Code §134.503, adopted to be effective January 3, 2002; amended to be effective January 1, 2011, set out the reimbursement guidelines for pharmaceutical services applicable to this dispute and is the version used throughout this decision.
6. 28 Texas Administrative Code §133.20, titled *Medical Bill Submission by Health Care Provider,* sets out the billing requirements.
7. The services in dispute were reduced/denied by the respondent with the following reason codes: for dates of service:

   Explanation of benefits dated February 13, 2012
   - 65 – Patient is not covered.

Issues

1. Were all the services in dispute filed in the form and manner prescribed by the division?
2. Is Eng's Pharmacy a health care provider?
3. Did the requestor bill in accordance with 28 Texas Administrative Code §134.503?
4. Did the respondent support their denial of "65 – Patient is not covered?"
5. Do the requestor and respondent have a negotiated or contracted agreement?
6. Is the requestor entitled to additional reimbursement?

Findings

1. This medical fee dispute was filed on January 20, 2012. The dates of service in dispute are July 26, 2011, September 22, 2011 and October 20, 2011; therefore, the requestor has met the requirements of 28 Texas Administrative Code §133.307(c) and the dates of service are eligible for review
2. Review of the documentation submitted finds that Eng's Pharmacy, the requestor in this medical fee dispute, is the health care provider because it is a health care facility as defined by the Texas Labor Code.
3. 28 Texas Administrative Code §134.503(b) states that "For coding, billing, reporting, and reimbursement of prescription and nonprescription drugs, Texas workers' compensation system participants shall apply the provisions of Chapters 133 and 134 of this title (relating to General Medical Provisions and Benefits—Guidelines for Medical Services, Charges, and Payments, respectively).
4. The respondent denied date of service October 20, 2011 using denial/reason code "65 – Patient is not covered." The respondent issued payment for date of service September 22, 2011; therefore, their denial is not supported.
5. In accordance with 28 Texas Administrative Code §134.503(c) the reimbursement for prescription drugs shall be as follows: (1) A negotiated or contract amount between the insurance carrier and the pharmacy, or the pharmacy processing agent, if applicable, that is greater than the reimbursement established by paragraph (3)(AA) of this subsection may be paid for prescriptions drugs used for an injured employee's claim at any time when it is necessary to secure health care for an injury employee; (2) A negotiated or contracted amount between the insurance carrier and the pharmacy, or the pharmacy processing agent, if applicable, that is less than the reimbursement established by paragraph (3)(A) of this subsection; or (3) In the event a negotiated or contract amount between the insurance carrier, pharmacy, or pharmacy processing agent does not exist, the lesser of: (A) the fee established by the following formulas based on the average wholesale (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed: (i) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee = reimbursement amount; (ii) Brand name drugs: ((AWP per unit) x

(number of units) x 1.09) + $4.00 dispensing fee = reimbursement amount; (iii) When compounding, a single compounding fee of $15 per prescription shall be added to the calculated total for either subparagraph (A)(i) or (ii) of this paragraph; or (B) the provider's billed amount.

6. 28 Texas Administrative Code §134.503(c)(2) is described as a "negotiated or contract amount." Documentation submitted by both the requestor supports that no contract exists between the respondent and requestor.
7. The maximum allowable reimbursement (MAR) is therefore based on the average wholesale price (AWP) as follows:

Dates of Service	Prescription Drug	Billed Amount	§134.503 (c) (3)(A)	Carrier Paid	Due
July 26, 2011	ZOLPIDEM TARTRATE 13668000801	$350.90	((4.62540 x 60) x 1.25) + $4 = $350.91	$0.00	$350.90
July 26, 2011	TIZANIDINE HCL 00185440051	$278.80	((1.46520 x 150) x 1.25) + $4 = $278.73	$0.00	$278.73
July 26, 2011	HYDROCODON-APAP 00406036162	$292.90	((1.15550 x 200) x 1.25) + $4 = $292.88	$0.00	$292.88
September 22, 2011	HYDROCODON-APAP 00406036162	$292.90	((1.15550 x 200) x 1.25) + $4 = $292.88	$292.88	$0.00
September 22, 2011	ZOLPIDEM TARTRATE 13668000801	$350.90	((4.62540 x 60) x 1.25) + $4 = $350.91	$350.90	$0.00
October 20, 2011	TIZANIDINE HCL 00185440051	$278.80	((1.46520 x 150) x 1.25) + $4 = $278.73	$0.00	$278.73
October 20, 2011	ZOLPIDEM TARTRATE 13668000801	$350.90	((4.62540 x 60) x 1.25) + $4 = $350.91	$0.00	$350.90
October 20, 2011	HYDROCODON-APAP 00591054001	$137.20	((0.53270 x 200) x 1.25) + $4 = $137.18	$0.00	$137.18
			TOTALS	**$643.78**	**$1,689.32**

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,689.32.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,689.32 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 28, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.